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Oxycontin Abuse:
Maine's Newest Epidemic

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Maine's Newest Epidemic

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Substance Abuse Services Commission
in conjunction with the
Maine Office of Substance Abuse

Many Thanks to:

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For their generosity in sharing their personal stories and expertise.

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Executive Summary

Oxycontin, a prescription pain medication introduced in 1995 has become a major drug of abuse in Maine over the past five years. Maine has gotten a great deal of publicity for its role as the first state to identify a problem with Oxycontin and other prescription narcotics. Substance abuse treatment admissions for narcotic abuse have increased 500%. Crime related to prescription narcotic abuse has increased dramatically, with opiate arrests now constituting nearly half of the Maine Drug Enforcement Agency's caseload. Abuse of prescription narcotics has caused an increase in emergency room admissions and a dramatic increase in the spread of hepatitis C in the drug using population.

The Substance Abuse Services Commission, an advisory group to the executive, legislative, and judicial branches of government conducted a six month study of the issue, and sought advice from a number of experts including medical, law enforcement and treatment professionals and recovering addicts. The recommendations from this study are as follows:

1. Increase access to treatment, especially detoxification services and treatments that are effective for opiate addiction.
2. Increase public education, particularly for children. Education on drug abuse needs to be regular and consistent, not sporadic.
3. Increase participation by school systems in the Maine Youth Drug and Alcohol Use Survey (MYDAUS), which will measure prescription drug abuse for the first time in 2002. Use MYDAUS data to further the development of a statewide prevention plan that involves all departments that provide services to youth and families.
4. Increase funding for law enforcement to address diversion of legal drugs to illegal use targeting areas of the state with the greatest need and the fewest resources.
5. Develop a statewide electronic prescription-monitoring program for Schedule II narcotics. This program should be similar to what is used by Medicaid and insurance companies already and should protect patient confidentiality by limiting access to the database.

What Is Oxycontin?

Oxycontin is a prescription pain medication introduced in 1995 by Purdue Pharma, a privately held pharmaceutical company. The drug that makes up Oxycontin, Oxycodone HCl, has been available for many years in lower dose forms or in combination with aspirin (e.g. Percodan) or acetaminophen (e.g. Tylox). What makes Oxycontin unique among products containing Oxycodone is its time-release formula that allows a larger dose to be administered at one time, but to be released into the blood stream over the course of twelve hours. Patients are able to take fewer pills per day. It is particularly useful for patients with chronic pain who, prior to its introduction, could not sleep through the night without waking for a dose of medication. It is available in 10 to 80 mg. doses. The 160 mg. dose which was previously available has been discontinued.

The package insert on the medication specifies several times that the pills are to be taken whole and that breaking, crushing, or chewing them will lead to a rapid release of the drug, which for patients who are not tolerant may prove fatal.

Oxycontin is a Schedule II narcotic that is highly regulated. Under the Controlled Substances Act of 1970, all potentially abused drugs are classified under Schedule I – V. Schedule I drugs are illegal and have no medical purpose. Schedule II drugs are legal for medical purposes, but have a high potential for abuse. Any one who wants to sell Schedule II drugs must register with the Drug Enforcement Agency (DEA) and use their registration number in any purchase or sale of the drug. They are required to account for every milligram dispensed, and must store the drugs under lock and key. Other Schedule II drugs that are commonly known are methadone, Adderall, and Demerol.

The Substance Abuse Services Commission

The Substance Abuse Services Commission was established by statute (Title 5, Ch. 521, subchapter 4-A, §20065) in 1993 to advise, consult and assist the Governor, the executive and legislative branches of state government and Chief Justice of the Supreme Judicial Court with activities of state government related to drug abuse including alcoholism.

Over the course of the past two years, Maine's growing problem with Oxycontin has received national attention. From the first story in the Bangor Daily News[1] in April of 2000 through recent press coverage in the Los Angeles Times[2], Maine is cited as one of the first places where Oxycontin abuse was identified. In fact, the director of the federal agency, Center for Substance Abuse Treatment, who came to Maine in August, 2000 to address the Bangor community on methadone treatment for opiate abuse, continues to say that he had not heard of the abuse of Oxycontin until he visited Maine.

Maine is cited as one of the first places where Oxycontin abuse was identified.

Over the past year, there has been much publicity regarding criminal behavior in addicts or dealers seeking Oxycontin. Rarely before have we heard of armed robberies at pharmacies where the robber asks for a specific drug and a specific dosage. Rarely before have the elderly and the terminally ill had their homes invaded by drug seeking criminals. Similar drugs have been available for many years, and we know there has been prescription drug abuse as long as there have been prescription drugs. The Commission convened a special sub-committee to seek answers as to why this drug seemed to be so different.

The Washington County communities that have been hit the hardest by abuse of this drug have cried out for help. Per capita use in the county is significantly higher than elsewhere in the state. Anecdotal accounts led us to believe that no one in the area had been untouched. In the past, drug fads have begun in urban areas, and often not made it to Maine, or came to our state several years later than other parts of the country (witness the current epidemic of methamphetamine abuse in the west which has not yet reached Maine, or the fact that club drugs, so popular in Europe and urban America have only gained widespread use in Maine within the past year.) The Commission set out to ask: what made Oxycontin the so-called "Hillbilly Heroin"?

Finally, in addition to seeking information, the Commission sought advice from the people most in touch with the epidemic. Law enforcement officials, medical professionals, treatment providers, and recovering addicts themselves were consulted to gain information and advice. The Commission wanted to know: what did they think needed to be done differently?

Fact-finding Methods

A subcommittee of the Substance Abuse Services Commission met from August through December. The committee gathered data from available sources including treatment admissions data from the Office of Substance Abuse, health statistics and hospital admissions from the Bureau of Health, local crime data from Uniform Crime Reports and the Maine Drug Enforcement Agency (MDEA), and death rate data from the Medical Examiner's Office, and national data from the Drug Enforcement Agency (DEA), and Drug Abuse Warning Network (DAWN).

In addition to compiling and analyzing existing data, the subcommittee on Oxycontin abuse held two focus groups: one for law enforcement officials and one for medical providers. The list of participants is in Appendix I. Finally, we interviewed drug addicts themselves. They were all in recovery, but their use was recent. The longest period of abstinence was less than a year, the shortest, just over one month. They had a great deal to say about the ease of access to illegal drugs, including illegally obtained prescription drugs, and the difficulty in accessing treatment services.

[Drug addicts] had a great deal to say about the ease of access to illegal drugs and the difficulty accessing treatment services.

History

There has always been some level of prescription drug abuse in Maine. "Doctor shopping" has been the most common method for obtaining prescription drugs. Patients had several doctors prescribing at one time for a variety of ills. Often patients would claim that a prescription was lost in order to get an additional one. Prescription drugs that were abused included narcotics: Dilaudid and Percocet for example, and other drugs like Valium, Xanax, and Ritalin.

Oxycontin was introduced in 1995. In 1996 Maine treatment providers began seeing a slow but steady increase in the numbers of people entering treatment for prescription drug abuse. This increase remained small but significant until 1998, when annual admissions for prescription drug abuse began an exponential growth curve which continued through July 2001, the most recent data available.

Figure 1:

Number of Clients Treated for Opiate Abuse by County of Residence

	1995	1996	1997	1998	1999	2000	2001
Androscoggin	22	15	8	15	16	24	29
Aroostook	5	7	8	18	17	24	46
Cumberland	103	131	116	168	238	346	386
Franklin	2	2	2	3	2	5	9
Hancock	1	7	3	8	15	31	61
Kennebec	18	20	20	39	64	31	8
Knox	9	14	16	18	25	30	52
Lincoln	3	2	9	15	11	9	18
Oxford	5	9	6	10	19	13	13
Penobscot	12	16	32	61	117	255	357
Piscataquis	4	1	4	6	3	7	16
Sagadahoc	6	8	6	7	8	22	34
Somerset	6	5	10	10	14	13	23
Waldo	5	8	4	12	8	20	30
Washington	9	15	21	46	81	160	144
York	20	24	26	39	69	97	66
Total	**230**	**284**	**291**	**475**	**707**	**1087**	**1292**

Source: Maine Office of Substance Abuse Treatment Data System. Data based on primary, secondary and tertiary drug identified at admission.

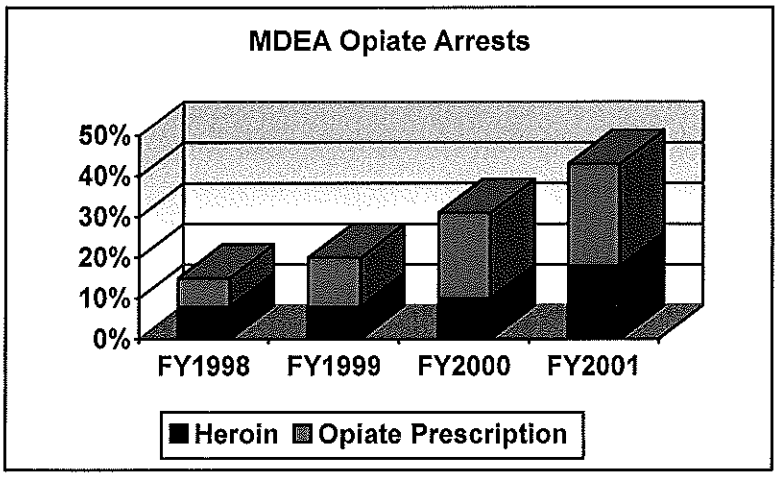
By mid 1999, it became clear to the Office of Substance Abuse that a methadone treatment program needed to be opened in the northern half of the state where most of the growth in prescription opiate abuse was occurring. OSA issued a Request For Proposals, and a grant was awarded to Acadia Hospital in December 1999.

The MDEA was confronted with the emerging issue of opiate abuse (heroin and prescription opiates) beginning three years ago. During 1998, MDEA started to receive reports of increased opiate prescription drug activity among drug users. This was followed by an increase in complaints involving opiate prescription fraud. Worthy of note was the age of those involved in opiate prescription drug use. Offenders ranged from high school age to those long known to law enforcement authorities for their substance abuse. Following close on the heels of increased prescription drug abuse, MDEA witnessed an increased activity in reports of heroin use and distribution.

The percentage of MDEA investigations that resulted in arrest for use and sale of opiates rose from 15% in FY1998 to 43% in FY2001 of all its cases (see Figure 2). MDEA's seizure of opiates has also increased dramatically. For FY2001, heroin seizures rose 171% over FY2000 amounts and

622% over FY1999 levels. The incidence of needles being discovered during the course of a drug search have become commonplace over this same time span.

Figure 2:



Source: Maine Drug Enforcement Agency.

Heroin and prescription opiate cases present challenges that the traditional illegal drugs do not. The major suppliers of heroin are located in northern Massachusetts. Because of this, it is difficult for Maine law enforcement to substantially impact heroin distribution. The usual Maine trafficker is an addict who turns to drug distribution to support his addiction. The addiction interferes with the addict's reliability when electing to cooperate with law enforcement in the investigation of the source of the supply of the drug. The same is true of the opiate prescription addict. The number of cases involving the acquisition of opiate prescriptions by defrauding physicians and pharmacists has extracted a tremendous toll on MDEA's resources.

According to Uniform Crime Reports data, arrests for synthetic narcotics have doubled over the past five years. What is dramatic about these arrests is the local nature of the problem. Oxford County had a significant decrease in arrests for sale or possession of synthetic narcotics between 1995 and 2000. There is no apparent widespread problem in that county as indicated by treatment, arrest, hospital admissions, or deaths. On the other hand, Washington County, which has been identified by all measures as having a significant problem, has had arrests grow eight-fold.

arrests for synthetic narcotics have doubled over the past five years.

Figure 3:

Uniform Crime Data: Adult Synthetic Narcotic Arrests

NAME	1995	1996	1997	1998	1999	2000
Androscoggin	12	31	8	2	13	12
Aroostook	9	2	26	27	8	18
Cumberland	16	22	26	25	51	50
Franklin	3	3	3	1	7	7
Hancock	0	2	7	2	1	0
Kennebec	11	6	10	11	7	15
Knox	6	6	3	13	12	12
Lincoln	1	0	0	2	3	2
Oxford	25	5	2	7	8	4
Penobscot	11	26	28	35	11	28
Piscataquis	1	0	0	0	0	0
Sagadahoc	2	0	0	2	1	0
Somerset	3	0	1	2	4	0
Waldo	0	0	3	3	1	3
Washington	7	6	14	4	9	58
York	8	21	18	11	25	30
State Totals	**115**	**130**	**149**	**147**	**161**	**239**

Source: Uniform Crime Report, Maine Department of Public Safety.

The Bangor Daily News published an investigative story in April, 2000 entitled "Narcotics Abuse on Rise, Pharmaceutical Drug Fraud, Misuse Worry Officials".[3] The story followed an addict and outlined the concern of law enforcement and treatment professionals in Washington and Penobscot Counties on what was fast becoming an epidemic in the area. The story broke the news of the impending opening of a methadone treatment program in Bangor, which launched a year of open public debate over the extent of the problem, and the appropriate ways to address it. This discussion became a national debate. Maine had been identified as the first state with a problem with Oxycontin abuse, but it was quickly followed by Kentucky, rural parts of Virginia, and West Virginia leading to the creation of the moniker "Hillbilly Heroin" for Oxycontin. Recently Ohio and Florida have begun to experience similar outbreaks of Oxycontin abuse and its concomitant problems.

The rural areas where abuse of Oxycontin began have a few things in common. They are small communities where poverty and unemployment are high. There is very little access to specialty medical care, and a high rate of chronic pain due to illness and injury. The culture in these areas already supported the norm of heavy use of alcohol and an acceptance of intoxication. All of these factors play into the rapid spread of prescription drug abuse.

Where are we now?

Despite anecdotal accounts to the contrary, there has not been a great surge in overdose deaths due to the abuse of Oxycontin. According to the Medical Examiner's office, in the year 2000, of 66 overdose deaths in Maine, nine involved the use of Oxycodone, the drug in Oxycontin. Some of these deaths included multiple drugs and it is impossible to determine that any one of the drugs was the cause of death. Unless the pills are found at the site of death, it is also difficult to determine what oxycodone-containing product was used. For example, someone could have Oxycodone, heroin, and methadone all in his blood at the time of death, and the medical examiner could not tell which drug was the cause of death, or whether the person had ingested Oxycontin, or Tylox.

As cited earlier, admissions to substance abuse treatment due to synthetic opiates such as Oxycontin have risen from 232 in 1995, the year Oxycontin was introduced, to 1299 in state fiscal year 2001.

As has been feared... Oxycontin seems to be a gateway drug to heroin.

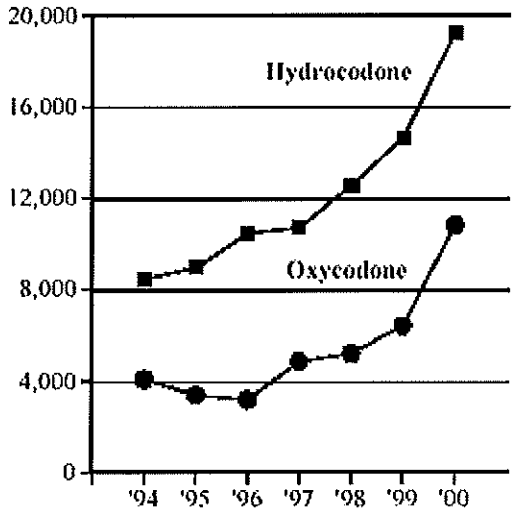
Heroin use has also been on the rise since 1998, nearly doubling in the past three years. As has been feared by some treatment providers and law enforcement officials alike, Oxycontin seems to be a gateway drug to heroin. Opiate addicts have gone from constituting 2% of the treatment population in 1995, to making up 12% of the treatment population in 2001. This is an unprecedented change.

While arrests due to the possession or sale of synthetic opiates have doubled in the past five years, law enforcement officials in some parts of the state say they are also plagued by property and personal crimes related to use of the drug. The Washington County sheriff's office reports an increase of 50% in crime, all due to prescription drug abuse. They have assigned two deputies to work exclusively on drug enforcement. This leaves the work they once performed to be picked up by other officers or to be left undone.

Pharmacy hold ups have been well publicized. Across the state, desperate drug addicts have broken into pharmacies or committed armed robberies in the middle of the day in order to get specific drugs including Oxycontin and Dilaudid. In some parts of the state, DEA agents spend nearly all of their time on investigating the diversion of legal prescription drugs for illegal purposes, leaving little time to chase down illegal drugs.

Hospital admissions for opiate related illness tripled between 1996 and 2000. In contrast, during the same period of time, admissions to the hospital for alcohol related causes remained steady. Maine is not alone in the increase in hospital visits due to opiate misuse. The national Drug Abuse Warning Network (DAWN) reports a 108% increase in emergency room mentions of oxycodone in the period from 1998 – 2000 (See Figure 4). Hydrocodone, the drug found in Dilaudid, has also caused a dramatic increase in Emergency Room visits.

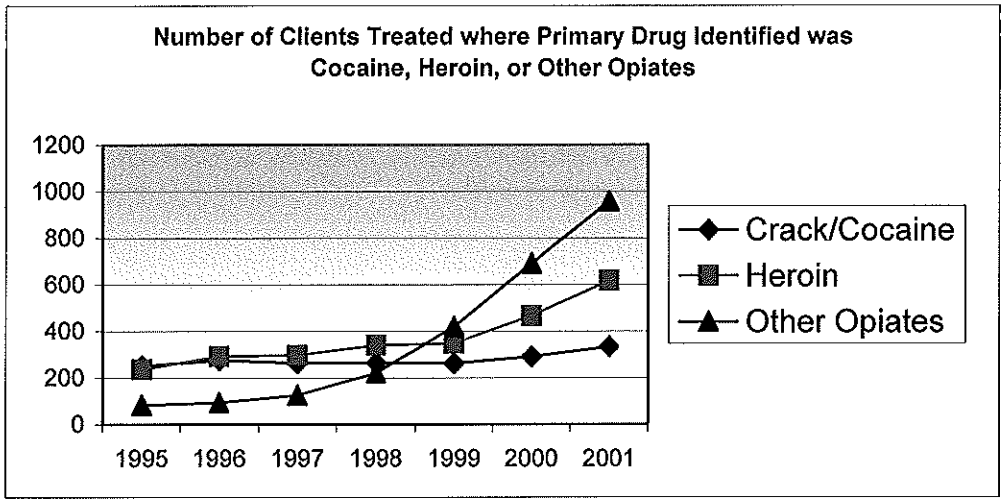
Figure 4:
Number of US Emergency Department Episodes Involving Hydrocodone and Oxycodone, 1994 – 2000



Source: CESAR Fax. 10(33) August 20, 2001 from SAMHSA Year-End 2000 Emergency Department Data from the Drug Abuse Warning Network (DAWN), July 2001.

Because of the negative publicity surrounding Oxycontin, doctors have reportedly become reluctant to prescribe the drug to all but their most needy patients. As the available supply of Oxycontin diminishes, treatment providers and law enforcement officials are both reporting a turn to other prescription drugs like Dilaudid, and to heroin.

Figure 5:



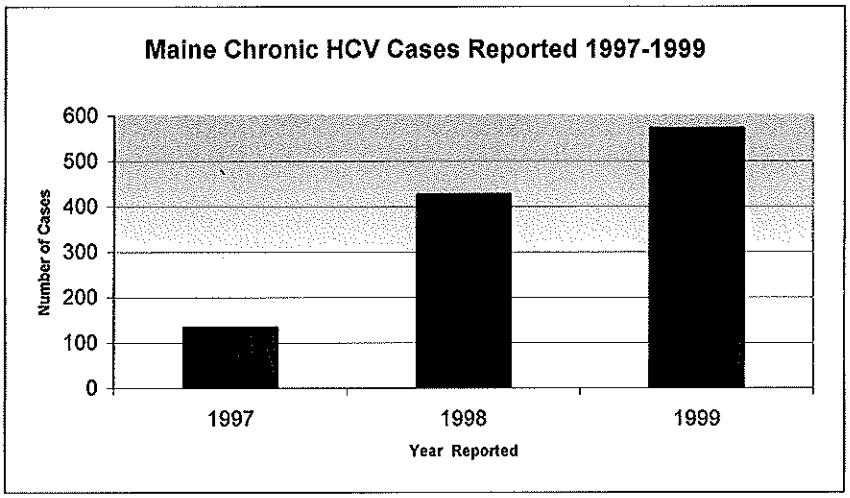
Source: Maine Office of Substance Abuse Treatment Data System

As the above graph indicates, the growth in heroin use seems to be following the same curve as other opiates, but is a few years behind. The growth in heroin use is particularly evident in Penobscot county. Oxycontin appears to serve as a gateway drug to heroin. According to users, its attraction is that it is a prescription drug with a specific and accurate dose. While many recreational drug users will shy away from heroin, with its negative image, there is none of that negative connotation with Oxycontin. In the initial stages of use it can be chewed or crushed and snorted. When users become tolerant, they eventually dissolve the pill in water and inject it. Once they become injection drug users, they have overcome a primary barrier to trying heroin. Heroin is often more available, and addicts are indiscriminate when they are in withdrawal and need a "fix".

Drug addicts are well aware of the dangers of heroin. The purity is always in question, and the dose is never assured. It is only when other preferable drugs like Oxycontin or Dilaudid become unavailable or too costly that addicts turn to heroin. Over the course of the past two years, everything has moved into place for Oxycontin addicts to move toward heroin: growing use of injection as a means of delivery, decreasing supply and increasing cost of prescription drugs, and increasing supply of heroin. In the past, only Cumberland and York counties had the demand for heroin that made it worth the risk for dealers, but increasingly northern parts of the state including Washington and Penobscot counties have a core group of addicts who are creating the market for heroin, and the dealers are moving in to supply it.

The increase in hepatitis C infection, particularly in Washington County is one indication of the growth of IV drug use. With growth in IV drug use, eventually there will be growth in AIDS in addition to Hepatitis C[4].

Figure 6:



Source: "At the Crossroads, Hepatitis C in Maine."[4]

Is Oxycontin different from other drugs?

There are some unusual aspects to this drug abuse epidemic. First of all, as a prescription drug, it is legal. Many people, like the elderly and disabled, who would never dream of selling illegal drugs have been drawn into the trade of Oxycontin because it is so lucrative. Addicts have pointed out that frequently they began by getting small amounts of the drug from "little old ladies" who had a legal prescription, but sold individual pills in order to pay for their prescription medications or to supplement their social security.

In the border towns, much of the drug is purchased in Canada. Like many other legal drugs, Oxycontin is cheaper in Canada, and people that have easy access cross the border to buy cheap drugs and return to sell them illegally at great markup – at times more than one dollar per milligram. Even with tighter border control due to the events of September 11, people are still able to walk drugs across the bridge into Calais or take one of the many ATV/snowmobile trails across the border.

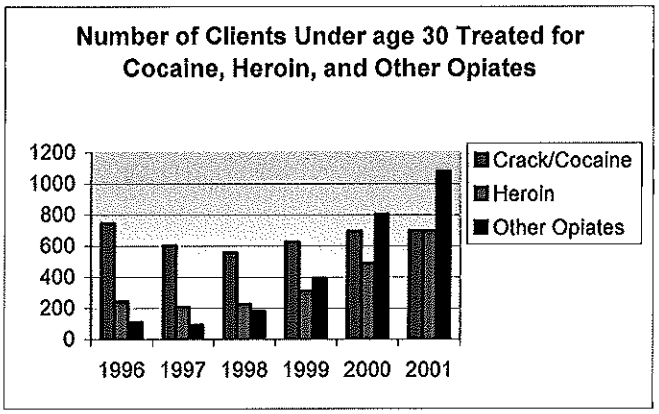
One of the most striking aspects of Oxycontin abuse that has left law enforcement baffled are the crimes that are committed in order to get the drugs. Armed robberies of pharmacies where the offender demands a specific drug was previously very rare. Law enforcement officials say the crimes that are committed seem more desperate – people commit them even though they know they will get caught. The closest parallel is the rash of break-ins of veterinary offices in the early 1990's to steal Ketamine, a veterinary tranquilizer. Pharmacies have had to install new alarm and video monitoring systems. Some have decided not to stock Oxycontin, providing it to regular customers on a per order basis only.

...the crimes that are committed seem more desperate – people commit them even though they know they will get caught.

It appears that prescription opiates may be one of the first drugs abused.

The other change that was identified by all those interviewed is the youth of people addicted to Oxycontin. Opiates used to be the end of the line for drug addicts, and people were in their late 30s or 40s before they sought treatment for opiate addiction. Now, in some circles it appears that prescription opiates may be one of the first drugs abused. Addiction has rapid onset with opiates, particularly among young people. Both law enforcement officials and treatment providers report that many young adults and even adolescents have developed problems.

Figure 7:



Source: Maine Office of Substance Abuse Treatment Data System. Data based on primary, secondary and tertiary drug identified at admission.

Focus Group Discussions

The experts that we consulted made two observations. The first is that we do not have just an Oxycontin problem, but an opiate problem. People often use a variety of prescription drugs interchangeably and that heroin use is on the rise as well as prescription opiates.

We do not have just an Oxycontin problem, but an opiate problem.

Secondly, they point out that in our effort to address the growth in opiate abuse, we cannot ignore the drug that causes the largest amount of damage in Maine: alcohol. While there has been significant and alarming growth in opiate use and the medical and criminal problems that it entails, it pales in comparison to alcohol whether looking at crime, emergency room and hospital admissions, or admission to substance abuse treatment. While opiate abuse, specifically IV drug abuse, has related public health risks like Hepatitis C and HIV infection, alcohol is involved with more traffic accidents, fires, falls and other accidents, more violence, and more physical illness.

We cannot ignore the drug that causes the largest amount of damage in Maine: alcohol.

Health Care

The medical providers feel that they are between a rock and a hard place. Physicians used to be fearful of over prescribing narcotics, but now pain is considered the 5th vital sign and treatment protocols require them to treat aggressively. The specialists commented that many things that were once referred to a specialist, like pain management or psychiatric diseases are now frequently treated by primary care physicians who do not have the same training. This change was attributed to managed care companies attempts to reduce costs by reducing physician visits of all kinds, reducing referrals to specialists, and encouraging treatment with medications. There was a general concern that the pendulum had swung too far. The physicians interviewed felt that doctors could use more education on addiction and drug seeking behavior. Addicts who had either doctor shopped or initially obtained the drugs for management of real pain suggested that doctors should provide more information to patients on the addictive aspects of the drug.

The physicians interviewed felt that doctors could use more education on addiction and drug seeking behavior.

Law Enforcement

Peter Arno of the Bangor Police Department described it as pushing water with a broom.

Both law enforcement officials and addicts believed that law enforcement was helpless in the face of the proportion of the problem. Peter Arno of the Bangor Police Department described it as pushing water with a broom. Law enforcement felt that when they had more DEA officers in 1992 they were much better able to address illegal drug trafficking. There was also a suggestion that it might be time for the DEA to develop a diversion division, rather than taking agents off of illegal drug investigations.

In contrast, all of the addicts reported that trafficking was too easy, and that no matter how many new law enforcement officers were added, two new dealers would pop up for every one arrested. All of those that had been arrested pointed out the stupidity of their crimes and how desperate they had become to be so stupid.

Treatment

There were a few universal recommendations. One was that access to treatment had to be expanded. Everyone had an anecdote about lost opportunity due to treatment waiting lists. Police officers in particular commented on the need for more treatment options. They cited a number of problems caused by lack of detox and emergency treatment services including, surprisingly, early discharge from jail in order to avoid withdrawal and medical treatment in jail. They reported that most opiate addicts when interviewed say they would like treatment, unlike people addicted to some other drugs. According to law enforcement officials, the addicts they encounter do not have denial and lack of motivation as a barrier to getting treatment. They are desperate for it.

Some had found success with methadone, others with residential treatment, none of those interviewed had succeeded with lower levels of care.

All of the addicts interviewed spent time on a waiting list for treatment. All of them said they would have benefited from medical detox prior to treatment. Several finally went out of state to get the treatment that they needed. Most had also experienced at least one prior treatment failure. The craving was so intense and

the withdrawal so painful that they couldn't stick with treatment. Some had found success with methadone, others with residential treatment, none of those interviewed had succeeded with lower levels of care.

One [universal recommendation was that] access to treatment had to be expanded.

Medical and treatment specialists all agreed that the lack of treatment options was an old problem that they had been discussing for years. George Higgens, MD believed that a motivated patient could get treatment in Portland, but someone that didn't believe they had a problem, or didn't want to deal with their problem was not going to get served. People from other areas of the state said that treatment was less available for anyone, motivated or not. Detoxification was specifically mentioned by all as a service that was not adequately available.

Prevention

Kids didn't believe that Oxycontin could be addictive, or any prescription drug could be dangerous.

Universally there was a sense that drug education had been inadequate. Several law enforcement and treatment providers pointed out the numbers of kids who didn't believe that Oxycontin could be addictive, or any prescription drug could be dangerous. They also expressed a need for consistent and ongoing prevention and education. They noted that education tended to be intermittent and not always delivered by someone to whom the kids would listen.

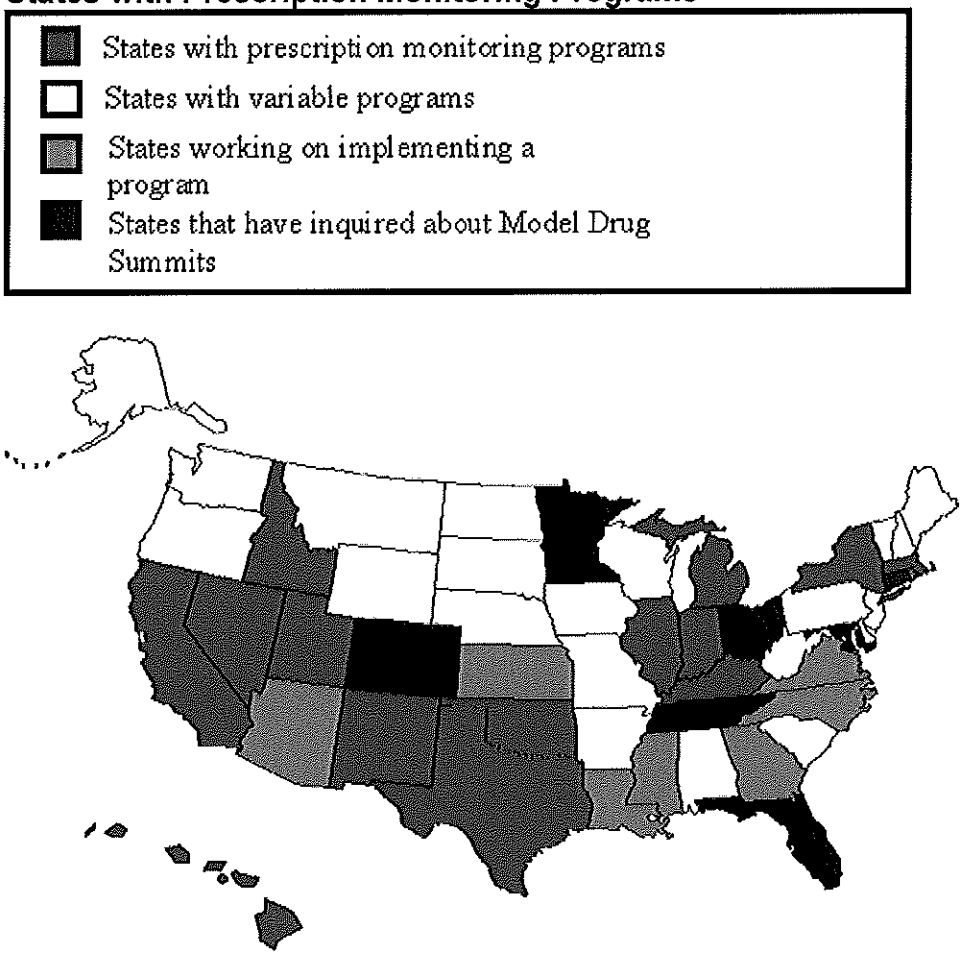
One recovering addict suggested that the drug itself needed to be changed.

One recovering addict suggested that the drug itself needed to be changed. That making it harder to eliminate the time-release coating would make the drug undesirable. "If we can't take it all at once, we won't want it any more." was his comment.

All of the people interviewed, law enforcement officials, medical providers, treatment providers, and addicts themselves agreed that an electronic prescription monitoring system would decrease diversion and help address the problem. Many states already have prescription monitoring programs, and most of those that have used triplicate prescriptions are moving toward an electronic monitoring system.

All agreed that an electronic prescription monitoring system would decrease diversion.

Figure 8:
States with Prescription Monitoring Programs



Source: "A Closer Look at State Prescription Monitoring Programs." U.S. Department of Justice, Drug Enforcement Administration, Diversion Control Program. www.deadiversion.usdoj.gov/pubs/program/rx_monitor/index.html

While the Maine Medical Association wants to ensure patient confidentiality and make sure the cost burden is not placed on physicians, they and the physicians interviewed felt that some sort of prescription monitoring program, preferably electronic, was a critical element in addressing prescription drug diversion.

Conclusion and Recommendations

Oxycontin and other prescription opiates have become a serious problem in Maine that has increased crime, emergency medical treatment, and spread Hepatitis C. It appears to be leading to an increase in heroin abuse. Its use began in poor rural areas where access to specialty medical care is limited and chronic illness and injury is high, but is has spread to many other areas of the state.

In order to address the dramatic problem of Oxycontin and other prescription drug abuse the Substance Abuse Services Committee makes the following recommendations:

1. Increase access to treatment, especially detoxification services and treatments that are effective for opiate addiction.
2. Increase public education, particularly for children. Education on drug abuse needs to be regular and consistent, not sporadic.
3. Increase participation by school systems in the Maine Youth Drug and Alcohol Use Survey (MYDAUS) which will measure prescription drug abuse for the first time in 2002. Use MYDAUS data to further the development of a statewide prevention plan that involves all departments that provide service to youth and families.
4. Increase funding for law enforcement to address diversion of legal drugs to illegal use targeting areas of the state with the greatest need and fewest resources.
5. Develop a statewide electronic prescription monitoring program for Schedule II narcotics. This program should be similar to what is used by Medicaid and insurance companies already and should provide limited access in order to protect patient confidentiality.

The Commission believes that with the implementation of these four recommendations, the prescription drug abuse problem in Maine could be significantly reduced.

Appendix I

Sub-Committee Members

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William Earle, PhD
Priscilla Guy
Paul McDonnell

Focus Group Participants

Peter Arno, Bangor Police Department
Joseph Loughlan, Portland Police Department
Michael Milburn, Chief of Police, Calais
Daniel Winslow, Chief of Police, Bangor
Daniel Bradford, Lincoln County Sheriff's office
Joseph Tibbetts, Washington County Sheriff

Paula Frost, Regional Medical Center at Lubec
John Stober, CEO, Regional Medical Center at Lubec
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Appendix III

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